Number	Category Name	Category Description	HL7 BH Conformance Profile Classification CM = Care Management
	Functional Requirements		
F01	***Identify and maintain a client record***	Key identifying information is stored and linked to the client record. Both static and dynamic data elements will be maintained. A look up function uses this information to uniquely identify the client.	DC \ Care Management
F02	***Manage client demographics***	Contact information including addresses and phone numbers, as well as key demographic information such as date of birth, gender, and other information is stored and maintained for reporting purposes and for the provision of care.	DC \ Care Management
F03	***Manage diagnosis list***	Create and maintain client specific diagnoses.	DC \ Care Management
F04	***Manage medication list***	Create and maintain client specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	DC \ Care Management
F05	***Manage allergy and adverse reaction list***	Create and maintain client specific allergy and adverse reaction lists.	DC \ Care Management
F06	***Manage client history***	Capture, review, and manage services/treatment, hospitalization information, other information pertient to clients care.	DC \ Care Management
F07	***Summarize health record***		DC \ Care Management
F08	***Manage clinical documents and notes***	Create, correct, authenticate, and close, as needed, transcribed or directly entered clinical documentation.	DC \ Care Management
F09	***Capture external clinical documents***	Incorporate clinical documentation from external sources.	DC \ Care Management
F10	***Generate and record client specific instructions***	Generate and record client specific instructions as clinically indicated.	DC \ Care Management

F11	***Order medication***	Create prescriptions or other medication orders with detail adequate for correct filling and administration.	DC \ Care Management
F12	***Order diagnostic tests***	Submit diagnostic test orders based on input from specific care providers.	DC \ Care Management
F13	***Manage order sets***	Provide order sets based on provider input or system prompt, medication suggestions, drug recall updates.	DC \ Care Management
F14	***Manage results***	Route, manage, and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.	DC \ Care Management
F15	***Manage consents and authorizations***	Create, maintain, and verify client treatment decisions in the form of consents and authorizations when required.	DC \ Care Management
F16	***Support for standard care plans, guidelines, protocols***	Support the use of appropriate standard care plans, guidelines, and/or protocols for the management of specific conditions.	DC \ Care Management
F17	***Capture variances from standard care plans, guidelines, protocols***	Identify variances from client-specific and standard care plans, guidelines, and protocols.	DC \ Care Management
F18	***Support for drug interaction***	Identify drug interaction warnings at the point of medication ordering	CM \ Clinical Decision Support

F19	***Support for medication or immunization administration or supply***	To reduce medication errors at the time of administration of a medication, the client is positively identified; checks on the drug, the dose, the route and the time are facilitated. Documentation is a by- product of this checking; administration details and additional client information, such as injection site, vital signs, and pain assessments, are captured. In addition, access to online drug monograph information allows providers to check details about a drug and enhances client education.	CM \ Clinical Decision Support
F20	***Support for non-medication ordering***	Referrals, care management	CM \ Clinical Decision Support
F21	***Present alerts for disease management, preventive services and wellness***	At the point of clinical decision making, identify client specific suggestions / reminders, screening tests / exams, and other preventive services in support of disease management, routine preventive and wellness client care standards.	CM \ Clinical Decision Support
F22	***Notifications and reminders for disease management, preventive services and wellness***	Between healthcare service/treatments, notify the client and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.	CM \ Clinical Decision Support
F23	***Clinical task assignment and routing***	Assignment, delegation and/or transmission of tasks to the appropriate parties.	CM \ Operations Management & Communication

F24	***Inter-provider communication***	Support secure electronic communication (inbound and outbound) between providers in the same practice to trigger or respond to pertinent actions in the care process (including referral), document non-electronic communication (such as phone calls, correspondence or other service/treatments) and generate paper message artifacts where appropriate.	CM \ Operations Management & Communication
F25	***Pharmacy communication***	Provide features to enable secure and reliable communication of information electronically between practitioners and pharmacies or between practitioner and intended recipient of pharmacy orders.	CM \ Operations Management & Communication
F26	***Provider demographics***	Provide a current directory of practitioners that, in addition to demographic information, contains data needed to determine levels of access required by the EHR security and to support the delivery of mental health services.	SS \ Clinical Support
F27	***Scheduling***	Support interactions with other systems, applications, and modules to provide the necessary data to a scheduling system for optimal efficiency in the scheduling of client care, for either the client or a resource/device.	SS \ Clinical Support
F28	***Report Generation***	Provide report generation features for the generation of standard and ad hoc reports	SS \ Measurement, Analysis, Research & Reports
F29	***Health record output***	Allow users to define the records and/or reports that are considered the formal health record for disclosure purposes, and provide a mechanism for both chronological and specified record element output.	SS \ Measurement, Analysis, Research & Reports

F30	***Service/treatment management***	Manage and document the health care delivered during an service/treatment.	SS \ Administrative & Financial
F31	***Rules-driven financial and administrative coding assistance***	Provide financial and administrative coding assistance based on the structured data available in the service/treatment documentation.	SS \ Administrative & Financial
F32	***Eligibility verification and determination of coverage***		SS \ Administrative & Financial
F33	***Manage Practitioner/Patient relationships***	Identify relationships among providers treating a single client, and provide the ability to manage client lists assigned to a particular provider.	SS \ Administrative & Financial
F34	***Clinical decision support system guidelines updates***	Receive and validate formatted inbound communications to facilitate updating of clinical decision support system guidelines and associated reference material	SS \ Administrative & Financial
F35	***Enforcement of confidentiality***	Enforce the applicable jurisdiction's client privacy rules as they apply to various parts of an EHR-S through the implementation of security mechanisms.	INI \ Security
F36	***Data retention, availability, and destruction***	Retain, ensure availability, and destroy health record information according to organizational standards. This includes: Retaining all EHR-S data and clinical documents for the time period designated by policy or legal requirement; Retaining inbound documents as originally received (unaltered); Ensuring availability of information for the legally prescribed period of time; and Providing the ability to destroy EHR data/records in a systematic way according to policy and after the legally prescribed retention period.	INI \ Health Record Information & Management

F37	***Audit trails***	Provide audit trail capabilities for resource access and usage indicating the author, the modification (where pertinent), and the date and time at which a record was created, modified, viewed, extracted, or removed. Audit trails extend to information exchange and to audit of consent status management (to support DC.1.5.1) and to entity authentication attempts. Audit functionality includes the ability to generate audit reports and to interactively view change history for individual health records or for an EHR-system.	INI \ Health Record Information & Management
F38	***Extraction of health record information***	Manage data extraction in accordance with analysis and reporting requirements. The extracted data may require use of more than one application and it may be pre-processed (for example, by being de-identified) before transmission. Data extractions may be used to exchange data and provide reports for primary and ancillary purposes.	INI \ Health Record Information & Management
F39	***Concurrent Use***	EHR system supports multiple concurrent physicians through application, OS and database.	SS \ Clinical Support
F40	***Mandated Reporting***	Manage data extraction accordance with mandating requirements.	SS \ Measurement, Analysis, Research & Reports
F41	***Administrative A/P E.H.R. Support***		
F42	***Administrative A/R E.H.R. Support***		
F43	***Administrative Workflows E.H.R. Support***		
	Security Requirements		
S01	**Security: Access Control**		
S02	**Security: Authentication**		

S03	**Security: Documentation**		
S04	**Security: Technical Services**		
S05	**Security: Audit Trails**		
S06	**Reliability: Backup/Recovery**		
S07	**Reliability: Documentation**		
S08	**Reliability: Technical Services**		
	Interoperability Requirements	**g**	
I01	**Laboratory**		DC \ Care Management
I02	**Imaging**		
I03	**Medications**		
I04	**Clinical Documentation**		
I05	**Chronic Disease Management/ Patient Documentation**		
I06	**Secondary Uses of Clinical Data**		
I07	**Administrative & Financial Data**		

MHSA - Behavioral Health Functional Functional Criteria MHSA Evaluation of EHRs

DRAFT

DMH EHR Functional Requirement Category Number	DMH EHR Functional Requirement Criteria Number	Specific Criteria	Discussion / Comments	EHR Road Map 1=Infrastructure 2=Practice Mgmt 3=Clinical Data 4=CPOE 5=Full EHR 6=Full EHR/PHR		Vendor Ratings Availability 2006	2007	2008	2009 and beyond
F-01	1.001	The system shall allow creation of an EHR that is uniquely associated to a single client.		2		H			
F-01	1.002	The system shall associate (store and link) key identifier information (e.g., system ID, health record number) with each client record.	Key identifier information shall be unique to the client record but may take any system defined internal or external form.	2		H			
F-01	1.003	The system shall provide functionality to record multiple non medical record identifier for single client. (e.g. SNN, pseudo SNN, and CIN, Drivers License or St ID#)	For interoperability, practices need to be able to store additional client identifiers. Examples include an ID generated by an Enterprise Master Patient Index, a health plan or insurance subscriber ID, regional and/or national client identifiers if/when such become available.	2		H			
F-01	1.004	The system shall provide a field to identify the identifier type.		2					
F-01	1.005	The system shall use key identifying information to identify (look up) the unique client record.		2		H			
F-01	1.006	The system shall provide more than one means of identifying (looking up) a client.	Examples of identifiers for looking up a client include date of birth, phone number.	2		H			
F-01	1.007	The system shall provide a field or fields which will identify clients as being exempt from reporting functions. Note: Work with DMH to review this item for Behavioral Health.	Examples include clients who are deceased, transferred, moved, seen as consults only. Being exempt from reporting is not the same as de-identifying a client who will be included in reports. De-identifying clients for reporting is addressed in the "Health record output" functionality.	2					

F-01	1.008	The system shall allow the user to choose from which reporting functions client identifiers shall be excluded.	Example: Exclude from case load reports but include in CSI reporting.	2					
F-01	1.009	The system shall be able to merge duplicate client records including claim data, demographic, financial, clinical and all service/treatment data.	If a duplicate chart is created, information could be merged into one chart.	2			H	X	
F-01	1.010	The system shall provide a mechanism for user to designate which merging data elements are to be retained as the primary record. Retain all records and mark the file as merged. Account for and store deleted MRN with cross reference.		2					
F-01	1.011	The system shall efficiently integrate with community resource databases, client wait lists, call logging, intake screening, pre-registration, registration , remote registration, and client referral systems which gather or distribute client demographic and financial information related to an existing or potential client.	Examples of caller data are date of call, staff receiving call, name, telephone number, language requirement, referring party, and call disposition.	2					
F-01	1.012	The system shall integrate with user-defined registration screens, that capture required federal, state, and local registration demographic and financial information.	Examples are: CSI, PATH, and SAMHSA , and UMDAP sliding scale data requirements.	2					
F-01	1.013	The system shall be easily configurable to support additional patient identification related to client service/treatment funding.	Examples are categorical funding and grants.	2					
F-01	1.014	The system shall cross check name inquiries to identify alias names.	Clients may have multiple alias names as well as other multiple Personal Identifiers such as Date of Births (DOB), Social Security Numbers, etc	2					
F-01	1.015	The system shall allow system administrators to link patient identifiers with client demographic data fields used for meeting local data requirements.		2					
F-01	1.016	The system shall automatically check for duplicates, i.e., entering a client with the same name and date of birth. If a suspected duplicate is found the system shall notify the user of the potential duplication and request confirmation of the entry.		2					
F-01	2.018	The system shall provide intake forms designed to display current data in the system, such as demographic items. The intake form can be designed to include various types of data including: free text, multiple choice, and drop down menu items.	Moved from 3.016	2					

F-02	**2.001**	The system shall capture and maintain demographic information as part of the client record. This information shall be able to be included in reports. Demographic data shall be able to accommodate minimum data sets as established by various regulatory bodies and reporting requirements..	Examples of a minimum set of demographic data elements include: name, address, phone number and date of birth. It is assumed that all demographic fields necessary to meet legislative and regulatory (e.g., HIPAA), research, and public health requirements will be included. A desirable feature would be a method of identifying how clients would like to be contacted (e.g., alternate addresses). De-identifying demographic information is addressed in the "Health record output" functionality.	**2**		H			
F-02	**2.002**	The system shall be able to maintain and make available historic information record using effective and end dates for demographic data including prior names, addresses, phone numbers and email addresses.	~~Providers need this for look up and contact purposes, e.g., when attempting to locate a client or family member for clinical communications.~~	**2**		M	H		
F-02	**2.003**	The system shall be able to maintain client contact/relationship information such as emergency contact and parents or guardians of children with effective dates. Includes ability to designate type of relationship and contact information.		**2**					
F-02	**2.004**	The system shall be able to import, create, review, modify, delete, and inactivate demographic information about the client.		**2**		H			
F-02	**2.005**	The system shall store demographic information in the client health record in separate discrete data fields, such that data extraction tools can retrieve these data.		**2**		M	H		
F-02	**2.006**	The system shall allow user to define additional fields to collect client demographic data required for California state-wide reporting.		**2**					
F-02	**2.007**	The system shall allow user to view client demographic data that has been created using an different name, alias, or patient identifying number.		**2**					
F-02	**2.008**	The system shall capture insurance information and responsible persons information including history of effective dates.		**2**					
F-02	**2.009**	The system shall be able to merge client demographic data if a client has more than one identical type data record opened erroneously.	Does not have to be only duplicate data found in both records.	**2**					

F-02	**2.010**	The system shall be able to display and review all data in two similar type client demographic records for the same client, highlighting the data that is different.	This will support determining the correct client demographic information that should exist subsequent to merging two records to one.	**2**					
F-02	**2.011**	The system shall require user confirmation prior to merging any client demographic information.		**2**					
F-02	**2.012**	If two client demographic records are erroneously merged, the system shall provide a mechanism for recreating them as separate records.		**2**					
F-02	**2.013**	The system shall provide a mini-registration process for clients who receive minimal service/treatments, requiring fewer mandatory fields to be completed.		**2**					
F-02	**2.014**	The system shall allow for the capture of limited pre-registration information when full registration cannot be completed.		**2**					
F-02	**2.015**	The system shall be able to store both permanent and temporary client addresses.		**2**					
F-02	**2.016**	The system shall be able to retrieve client information by: Client name, Client identification number, date of birth, social security number, or alternate name.	Examples of alternate names: Alias, maiden name, or prior legal name.	**2**					
F-02	**2.017**	The system shall allow the user to efficiently navigate between client registration and other screens without loss of registration data already inputted.	Examples of other screens: Scheduling, billing, client identifier lookup, and service/treatment records lookup.	**2**					
F-02	**2.019**	The system shall provide the ability for the client to enter in their demographic, insurance information, family history, social history and prior medical history via an in-office kiosk.		**2**					
F-15	**15.001**	The system shall be able to capture scanned paper consent documents (covered in DC.1.1.3.1).		**2**		H			
F-15	**15.002**	The system shall be able to store, display and print client consent forms.	Example: Consent forms stored in the computer which are capable of being signed by the client with either an electronic pen or a digital signature once widely available.	**2**		M	H		

F-15	15.003	The system shall allow clients to electronically sign consent forms using California DMH approved digital signature standards. Electronically signed consent forms shall be maintained within the client health record.	The words, "sign," "signature," "cosign," and "cosignature" are intended here to convey actions, rather than referring to digital signature standards. It is recognized that an electronic signature is useful here. However, a widely accepted standard for electronic signatures does not exist. Thus, the criteria calls for documenting the actions of authenticated users at a minimum. In the future, when appropriate digital signature standards are available, certification criteria shall be introduced using such standards.	2					
F-15	15.004	The system shall allow secure consents and authorizations to be electronically received for immediate review.		2					
F-15	15.005	The system shall be able to store and display administrative authorizations (e.g. privacy notices).	Needed for HIPAA. Scanned copy is acceptable for 2007.	2		M	H		
F-15	15.006	The system shall be able to store and display client consents associated with a specific clinical activity and be able to link to that event in the client's electronic chart.		2		M	H		
F-15	15.007	The system shall be able to chronologically display consents and authorizations.	This includes consents and authorizations relative to PHI and service/treatment authorization.	2		M	H		
F-15	15.009	The system shall notify users of missing or expired authorizations for service/treatment during the data entry process.	Moved from 30.008	2					
F-20	20.001	The system shall be able to create referral orders with detail adequate for correct routing.	This could include referrals to sub-specialists, physical therapy, speech therapy, nutritionists, and other non-medication, non-clinical order. Adequate detail includes but is not limited to: • Date • Patient name and identifier • "Refer to" specialist name, address and telephone number • "Refer to" specialty • Reason for referral • Referring physician name	2		M	M	H	

F-20	20.002	The system shall record user ID and date/time stamp for all referral related events.	Necessary for medico-legal purposes. Security	2		M	M	H	
F-20	20.003	The system shall track consultations and referrals.		2					
F-20	20.004	The system shall be able to print consultation and referral forms.		2					
F-24	24.001	The system shall be able to document verbal/telephone communication into the client record.		2		H			
F-24	24.003	The system shall support messaging between users.	Results and other client data could be included. As clarification, messaging is defined as any text string sent from one person to another in the office.	2		H			
F-26	26.001	The system shall be able to maintain a directory of all clinical personnel who currently use or access the system.	See CA. E.H.R. Behavioral Health Security Criteria	2		H			
F-26	26.002	The system shall support the collection of several user-defined clinician identifiers such as location, credentials, language, days and times worked, and specialties. Credentialing and certification data shall include effective and expiration dates.	Identifiers include credentialing such as state licensure (MD, MFCC, LCSW, MFT, LPT. Etc.) DEA, NPI, and UPIN numbers. This directory may be the same as that in criterion #1 for this functionality.	2		H			
F-26	26.003	The system shall provide validation at the point of service entry that the rendering provider is credentialed to provide the service/treatment.	For example, mental health worker is not credentialed to perform medical medication support service/treatments.	2					
F-26	26.004	The system shall be able to maintain a directory that stores user attributes required to determine the system security level to be granted to each user.	This directory may be the same as that in criterion #1 for this functionality.	2		H			
F-26	26.005	The system shall allow authorized users to update the directory.		2		H			
F-26	26.006	The system shall be able to create and maintain a directory of clinical personnel external to the organization who are not users of the system to facilitate communication and information exchange.	This directory may be the same as that in criterion #1 for this functionality.	2		H	L	H	
F-26	26.007	The system shall support the development of user-defined screens to register, track and report on Provider Organizations and Individual Clinicians that contract with the counties.		2					
F-26	26.008	The system shall support managing data from both contracted clinicians who are part of the external provider network and employee clinicians who staff the county clinics, 24-hour facilities, and community-based programs.		2					

F-26	26.009	The system shall supports the assignment of registered providers (internal or external) to specific fee schedules, specific health plans, specific procedure codes, or groupings of these attributes in a manner that is easy to set up and manage on an ongoing basis.		2					
F-27	27.001	The system shall display a schedule of client appointments, populated either through data entry in the system itself or through an external application interoperating with the system.	Displays are intended to be restricted to authorized viewers.	2		H			
F-27	27.002	The system shall interface to a front-desk environment electronic staff scheduler common to busy public sector clinic settings.	The system supports common inquiries such as “find first available appointment for Dr. X”.	2					
F-27	27.003	The system shall support a user-friendly maintenance of an electronic staff scheduler, noting staff available and non-available hours.		2					
F-27	27.004	The system shall interface to an electronic staff scheduler with daily rosters of appointments and “chart pull” lists that can be generated on demand.		2					
F-27	27.005	The system shall interface to a flexible electronic staff scheduler that allows appointment scheduling several months in advance to accommodate medication management and other service/treatments.		2					
F-27	27.006	The system shall interface to an electronic staff scheduler that allows entry of recurring appointments.		2					
F-27	27.007	The system shall interface with an electronic scheduler that makes appointments for clinicians, rooms, other facilities, and vehicles.		2					
F-27	27.008	The system shall interface with common third-party available appointment scheduling or calendaring software.		2					
F-27	27.009	The system shall allow a user to create or select a provider/client appointment by usage of the following parameters:: Client identifier, date, next available appointment date, time of day, type of visit, provider(s) availability, interpreter availability, location, room, or special equipment.		2					
F-27	27.010	The system shall allow comment entry during appointment creation. As appropriately authorized, this comment shall be viewable, or printable on all scheduler outputs.		2					
F-27	27.011	The system shall be able to enter a client’s reason for requesting appointment (60 characters minimum) when scheduling an appointment.		2					
F-27	27.012	The system shall be able to book one or multiple appointments into an appointment slot.		2					

F-27	27.013	The system shall be able to define the multiple/overbooking limits.		2					
F-27	27.014	The system shall warn the user when the expected maximum number of clients has been appointed to the slot and allows overbooking.		2					
F-27	27.015	The system shall be able to modify an appointment to change the required amount of time allotted. This change affects only the particular day's schedule for the specified provider/clinic.		2					
F-27	27.016	The system shall inform the user of conflicting appointments on the schedule for the specified client.		2					
F-27	27.017	The system shall allow the user to create, modify, or delete types of appointments and to allocate an estimated amount of provider/clinic time needed for each appointment type.		2					
F-27	27.018	The system shall allow the user to designate time frames during which individual providers or clinic resources are not available.		2					
F-27	27.019	The system shall allow the user to book an appointment or generate a reminder for an appointment up to one year in the future.		2					
F-27	27.020	The system shall allow the user to view schedule appointments by scrolling backwards as well as forwards through schedule appointments.		2					
F-27	27.021	The system shall assist the user in coordinating appointments with multiple providers addressing multiple problems during one visit.		2					
F-27	27.022	The system shall allow users to search for reserved blocks of time.		2					
F-27	27.023	The system shall allow for override of reserved blocks with other visits, and can place time restrictions on blocks (e.g., can only be scheduled one day in advance.)		2					
F-27	27.024	The system shall be able to cancel a specified appointment that has been booked and to specify the reason for the cancellation.		2					
F-27	27.025	The system shall make a canceled appointment slot available immediately for rescheduling.		2					
F-27	27.026	The system shall be able to cancel all appointments scheduled for a provider in a selected timeframe and to print a report with contact information for all clients affected by the cancellation.		2					
F-27	27.027	The system shall be able to generate mailing labels and reminder letters to clients for missed, canceled, scheduled or rescheduled appointments.		2					

F-27	**27.028**	The system shall allow the user to view, cancel, and reschedule all appointments for the client.	Especially useful, when a client misses or cancels the first of a series of appointments.	**2**					
F-27	**27.029**	The system shall allow display of all future appointments for a given client or group of clients. For each appoint, this display shows, at a minimum, the following: Provider/clinic, appointment date, appointment time, appointment duration, appointment comment (30 characters minimum), client's reason for making appointment, type of visit, special equipment or room needed, client's account balance, client's payor eligibility(ies).		**2**					
F-27	**27.030**	The system shall allow viewing of a provider's/clinic's schedule either as a display or in hardcopy form. This output shows one day at a time, week-at-a-glance, or month at-a-glance.		**2**					
F-27	**27.031**	The system shall allow viewing of a schedule of clinic resource requirements on demand.		**2**					
F-27	**27.032**	The system shall allow printing of the day's schedule for a specified site, in sequence by appointment time.	Output shall show at least the following data for each appointment: Client name, list of names for group visit, client chart number(s), guarantor name and relationship, client(s) phone number(s), appointment time, appointment comment, client's reason for making appointment, provider name(s), client account status indicator or code, client account balance, date of last payment, and new client indicator.	**2**					
F-27	**27.033**	The system shall provide schedule lists able to be sorted by: Client name , user-selected date range, new clients, walk-ins, and no-shows.		**2**					
F-27	**27.034**	The system shall allow the system manger to specify a schedule template which outlines the typical week's available appointment slots and specifies a visit type, duration, and expected maximum number of clients for each slot. Slots are available for same-day visits.		**2**					
F-27	**27.035**	The system shall allow a system manager to enter and edit a list of holidays in the system and thereby remove these days from all available schedules.		**2**					
F-27	**27.036**	The system shall allow a system manager to enter and edit a list of leave days during which a particular provider shall not be available for appointments.		**2**					

F-27	27.037	The system shall be able to produce a chart pull list for each site. The chart pull list shows the following data, at a minimum for each appointment: Client name, client chart number, client date of birth, client gender, client appointment date/time, client telephone number and address, provider name.		2					
F-27	27.038	The system shall maintain a client waiting list, which can be called up when a client cancellation occurs.		2					
F-27	27.039	The system shall register attendance for the schedule appointment when the client's visit to the clinic is entered.		2					
F-27	27.040	The system shall produce follow-up address labels for user-selected clients.		2					
F-27	27.041	The system shall produce a report of patient who missed appointments (a "no show" report) in a user-selected date/time period.		2					
F-27	27.042	The system shall maintain a history of clients that miss and cancel appointments and can produce a report of contact information for these clients including reasons for cancellations.		2					
F-27	27.043	The system shall be able to generate letters to clients reminding them of their scheduled appointments.		2					
F-27	27.044	The system shall be able to print a charge ticket (super bill) before the appointment or when the patient arrives and checks in.		2					
F-27	27.045	The system shall allow the user to create or edit multiple reminder and/or follow-up letters generated by the scheduling module so that letters can be produced in the appropriate language for selected patients.		2					
F-27	27.046	The system shall print on scheduling output client co-payment amount due, service/treatment authorization expiration date and /or insurance expiration date.		2					
F-28	28.001	The system shall be able to generate reports of clinical and administrative data using either internal or external reporting tools.	Needed for pay for performance, quality improvement activities. All data that is entered in a structured format shall be individually reportable.	2		M	H		
F-28	28.002	The system shall be able to generate reports consisting of all or part of an individual client's health record (e.g. client summary).	Report format may be plain text.	2		H			
F-28	28.003	The system shall be able to generate reports regarding multiple clients (e.g. group therapy).	Any disease registry might be included.	2		M	M	H	

F-28	28.004	The system shall provide users the ability to specify report parameters (sort and filter criteria) based on various variables.	Example variables are: 1) client demographic and clinical data (e.g., all male clients over 50 that are diabetic and have a HbA1c value of over 7.0 or that are on a certain medication). Minimum demographic data are age and gender.; 2) date ranges; 3) program type; 4) Organizational department; 5) Provider.	2		M	H		
F-28	28.005	The system shall be able to access reports external to the EHR application. ?????	For example, printed output, export to a file, etc.	2		H			
F-28	28.006	The system shall be able to produce reports based on the absence of a clinical data element (e.g., a lab test has not been performed or a blood pressure has not been measured in the last year).		2		L	L	H	
F-28	28.007	The system shall be able to save report parameters for generating subsequent reports.		2		M	M	H	
F-28	28.008	The system shall be able to modify one or more parameters of a saved report specification when generating a report using that specification.		2		M	M	H	
F-28	28.009	The system shall be easily configured to allow creation of a variety of outcome measurement instruments.	Locally defined as well as third party licensed scoring protocols can be used to summarize outcome instrument data.	2					
F-28	28.010	The system shall allow third party licensed instruments to be incorporated into the system for authorized use. Clinical review of outcome score trends over time is available as on-line queries for clinical decision-making.		2					
F-28	28.011	The system shall allow on-line clinical review of outcome score trends over time.	This capacity is intended to support clinical decisions.	2					
F-28	28.012	The system shall provide report capability relevant to all requirements listed in this document.	What does this mean?	2					
F-28	28.013	The system shall have the option of outputting reports to the screen, printer, standard ASCII file format and PC application formats such as XLS, CSV, PDF, MDB, TXT, DIF, etc.		2					
F-28	28.014	The system shall allow standard reports to be copied, edited and added to the reports menu with a new report name.		2					
F-28	28.015	The system shall have standard management reports that provide a variety of management views such as monthly trend reports, clinician comparison reports, program costs, etc.		2					

F-28	**28.016**	The system shall supports the collection, compilation, reporting and analysis of the California-mandated Performance Outcome System (POS) client outcome and satisfaction reports including: the Youth Services Survey (YSS), Youth Services Survey for Families (YSS-F), MHSIP Consumer Survey, and California Quality of Life (CA-QOL).		**2**					
F-28	**28.017**	The system shall support the reporting and data analysis of the county's quality assurance programs.	Quality Assurance: The development and production of reports based on payor and county identified performance and outcome measures for access, assessment, service/treatment planning, service/treatment delivery, etc. Also aids random chart sampling and review processes.	**2**					
F-28	**28.018**	The system shall support the reporting and data analysis of the county's quality improvement programs.	Quality Improvement: The development and production of reports that track and trend quality measures over time and can support the identification of variation that is material and statistically significant.	**2**					
F-28	**28.019**	The system shall support the reporting and data analysis of the county's utilization review programs.	Utilization Review: The development and production of reports that track utilization throughout the county and identify specific clients, clinicians, service/treatments, and/or programs that are above or below user-designated trigger thresholds.	**2**					
F-28	**28.020**	The system shall include an integrated, user-friendly report writer that has the capability of reporting on any combination of data fields in the entire system including user-defined fields; can perform multi-layered sorts and selects; has the ability to utilize wild cards in any data position of a field to select items; has the ability to compute on any field or combination of fields.		**2**					
F-28	**28.021**	The system's report writer shall generate both ad hoc query-type results and formatted reports whose production can be scheduled, produced and distributed electronically on an ongoing basis.		**2**					

F-28	**28.022**	The system 's report writer shall be integrated such that the running of reports against the production database will not create noticeable degradation in the response time of staff that are entering transactions and using the system's various lookup features.		**2**					
F-28	**28.023**	The system's report writer shall all the user to output results to the screen, printer, standard ASCII file format and PC application formats such as XLS, CSV, PDF, MDB, TXT, DIF, etc.		**2**					
F-28	**28.024**	The system shall allow any interfaced external SQL-compliant third-party report writer applications such as Crystal Reports, Microsoft Access, or R&R Report Writer to report on any combination of data fields in the entire system including user-defined fields.		**2**					
F-28	**28.025**	The system shall support a letter writing/mail merge function where third party word processing programs such as Microsoft Word can be integrated with the system to produce letters to clients, clinicians and other parties.		**2**					
F-28	**28.026**	The system shall support letter templates to be added to system menus and automatically generated based on Workflow Management rules or components.	Examples include the generation of a referral letter to clinician and client when a referral is created, and generation of a follow-up letter when an appointment is recorded as a missed appointment.	**2**					
F-28	**28.027**	The system shall support the development of standard data rectangles based on predefined views that can be exported to common third party products such as Microsoft Excel and Microsoft Access.		**2**					
F-28	**28.028**	The system shall mirror the production database to a reporting server, which uses the Integrated Report Writer and/or an Alternative Report Writer to produce user-developed reports and ad hoc queries		**2**					
F-28	**28.029**	The system shall supports the extraction, transformation, and loading of all data from the system into a Data Store containing denormalized and summarized data, which is used for data analysis and reporting.		**2**					
F-28	**28.030**	The system shall have user-friendly ability to maintain and manage the extraction, transformation and loading processes related to a Data Store during system data dictionary management.		**2**					
F-28	**28.031**	The system shall have documentation which includes a complete data dictionary and Entity Relationship Diagram of all of the tables, table relationships, fields, and field attributes.		**2**					

F-28	28.032	The system shall support internal or alternative report writers drill-down reporting that allow users to examine the underlying data behind figures on the report.		2					
F-28	28.033	The system shall allow users to schedule report production requests for regular periodic processing according to specified criteria such as one or more times per day, weekly on specified day, monthly on first day of month and fiscal period, etc. Specification of data ranges to be included in reports shall be allowed to differ from the scheduled date/time of the execution of the report.		2					
F-28	28.034	The system shall provide predefined views of data sets that merge data from multiple tables into logical reporting groupings to assist non-technical users in creating new standard, management, and ad hoc reports. The system supports the development of views based on groupings of client attributes such as user-defined population cohorts, geographic clusters of zip codes, groupings of client eligibilities, etc. Views can include core fields as well as any user-defined field added to the system.	Example views include Clients, Clinicians, service/treatments, and Authorizations.	2					
F-28	28.035	The system shall support the development of views based on groupings of client attributes such as user-defined population cohorts, geographic clusters of zip codes, groupings of client eligibilities, etc.	Views can include core fields as well as any user-defined field added to the system.	2					
F-28	28.036	The system shall efficiently interface with bi-directional reporting transfer of data with state and county systems as well as with other business associates.		2					
F-28	28.037	The system shall have reporting interfaces that support healthcare application-level transaction standards including, but not limited to HL-7 and ASC X12N; support the translation of data sets based on pre-defined translation code tables; support the development of error-checking routines, flagging via error reports, and the ability to readily resolve non-matching data.		2					
F-28	28.038	The system shall allow trained county staff to maintain and modify reporting interfaces in response to specification changes from payors and business associates.		2					
F-28	28.039	The system shall generate an evaluation survey (scheduled and on-demand) that shall record patient satisfaction.		2					
F-28	28.040	The system shall support real-time or retrospective trending, analysis, and reporting of clinical, operational, demographic or other user-specified data.		2					

F-28	28.041	The systems shall produce reports of usage patterns.		2					
F-28	28.042	The system shall able to perform automatic cost analysis for courses of drug service/treatments.		2					
F-28	28.043	The system shall allow users to develop utilization, statistical and productivity reports on user-determined data fields.		2					
F-28	28.044	The system shall able to produce population-based studies based on flexible, end-user modifiable criteria.		2					
F-28	28.045	The system shall provide that ability to produce scheduled and on-demand case mix reports.		2					
F-28	28.046	The system shall have a tracking mechanism for assessments, service/treatment plans and updates, progress notes, discharge summaries for reminders in the form of a tickler list to the staff member involved.		2					
F-28	28.047	The system shall able to create reminders to clients, particularly for missed appointments or reminders for upcoming appointments.		2					
F-30	30.016	The system shall provide user immediate data entry error notifications with data entry functions..		2					
F-30	30.021	The system shall support the efficient management of group service/treatments. Participants in the group may be coordinated by several different teams within the same agency.	Groups can easily be created, clients added and deleted from particular groups. When service/treatments are entered for a group, all group members are displayed for rapid data entry.	2					
F-30	30.022	The system shall allow for a therapist and co-therapist to have different billing times including different documentation time per client.		2					
F-30	30.023	The system shall support that participants in a group therapy may be coordinated by several different teams within the same agency.		2					
F-30	30.027	The system shall be able to flag, prevent or suspend service/treatment entry outside scope of practice. (i.e. CBT..)	Moved from Administrative Workflow 43.036 . Review again	2					
F-31	31.002	The system shall be able to select an appropriate CPT Evaluation and Management code based on data found in a clinical service/treatment.	May be accomplished via a link to another application.	2		H			
F-31	31.003	The system shall have the ability to provide assistance in selecting appropriate billing codes based on codified clinical information in the service/treatment.	Criterion satisfaction will require that the system can automatically count elements in the history and examination documentation to accomplish this calculation. MDM complexity will still require specification by the provider/coder.	2		L	L	H	

F-31	31.004	The system shall provide the ability to link the most current procedure code with the current service/treatment plan.		2					
F-31	31.005	Charge Capture: The system shall post charges for more than one day for one patient on one screen.		2					
F-31	31.006	Charge Capture: The system shall automatically capture of Evaluation and Management (E&M) codes based on clinical data in the EHR based on rules.		2					
F-31	31.007	Charge Capture: The system shall adhere to Correct Coding Initiative (CCI) and Local Medical Review Policy (LMRP) edits		2					
F-31	31.008	Charge Capture: The system shall adhere to Correct Coding Initiative (CCI) and Local Medical Review Policy (LMRP) edits		2					
F-31	31.009	Charge capture: The system shall provide base line charge capture and the ability to submit the charges to a current or future practice management system.		2					
F-31	31.010	Charge capture: The system shall provide E & M coding guidelines that are designed to insure that the actual charges match the clinical charting. [Note: Need help here – more Coalition language? – UMDAP etc.]		2					
F-31	31.011	Charge capture: The system shall provide charge capture for both nurses and physicians following the 1997 E & M coding requirements.		2					
F-31	31.012	Charge capture: The system shall track the number of points per E & M coding category and provides the provider with a one page summary of the appropriate E & M code. [Note: Would change this to include the partial billing by minutes for group therapy as noted in the Coalition documents.]		2					
F-31	31.013	Charge capture: The system shall provides nationally recognized, practice customized E & M coding tied to the patient's specific healthcare plan for maximizing charge capture via pre-authorization alerts and guidelines.		2					
F-31	31.014	Charge capture: The system shall provide advice in charge capture based on best practices, practice guidelines and reports variances from guidelines.		2					
F-32	32.001	The system shall be able to display eligibility obtained from client's insurance carrier, populated either through data entry in the system itself or through an external application interoperating with the system.	The EHR need only provide information for the physician as to whether the client is covered by that insurance plan. This can be accomplished by a text note following telephone verification.	2		L	L	H	
F-32	32.002	The system shall be capable of electronically receiving and displaying prescription benefits eligibility information.	Will be required by e-prescribing	2		L	L	H	
F-32	32.003	The system shall support monthly loading of the Medi-Cal Eligibility Determination System (MEDS) files from the state.		2					

F-32	32.004	The system shall assure that all eligible enrollees have a new record added to the county system for Medi-Cal eligibility each month, including all retroactive additions to Medi-Cal.	The eligibility system shall maintain eligibility records for all county eligibles in the state monthly download file, not just individuals who are enrolled as clients.	2					
F-32	32.005	The system shall be capable of compliance with the ASC X12N 270/271 - Eligibility for a Health Plan and ASC X12N 834 - Enrollment and Disenrollment formats.	To be used for benefit eligibility determination in Medi-Cal, Medicare, Insurance, and other third party payor systems.	2					
F-32	32.006	The system shall support evaluation of third party payor eligibility for registered clients.		2					
F-32	32.007	The system shall support monthly , or greater frequency, determined by the county, Medi-Cal eligibility evaluation of registered clients		2					
F-32	32.008	The system will allow users the option of updating client insurance records automatically or through computer-assisted manual updates when: 1) an automated eligibility process identifies clients where no prior eligibility had been determined ; 2) where the eligibility status has changed, including retro-active updates for clients previously served,	The process shall include assigning or updating the cascade level of insurance plans that have been changed for a client, identifying clients who have lost their insurance coverage, and determining how previous billings shall be adjusted.	2					
F-32	32.009	The system shall support the manual on-line review and update of insurance records for clients with various special handling conditions including: a partial eligibility match requiring investigation, Medi-Cal Share of Cost responsibility, CMSP eligibility, other state aid codes, Medicare, private insurance, and Medi-Cal clients with a different responsible county. Changes made through the automated insurance eligibility determination process shall be supported with a complete audit trail.		2					
F-32	32.010	The system shall support a real-time interface to the Medi-Cal Point of Service MEDS database for viewing a client's current eligibility status for Medi-Cal and other included payors.		2					
F-32	32.011	The system shall allow a user to poll the Medi-Cal Point of Service MEDS database and then easily update a client's eligibility and insurance coverage records if the coverage has changed.	For Medi-Cal clients this includes entry of the Medi-Cal Eligibility Verification Code (EVC) or, in the absence of an EVC, entering the Primary Aid Code and County Code to support the eligibility status.	2					
F-32	32.012	The system shall support easy identification and clearance of a client's Share of Cost obligation, ensuring that those service/treatments are not billed to Medi-Cal.		2					

F-32	32.013	The system shall support easy access to a client's locally stored eligibility records for eligibility lookup from various components and modules including Call Logging, Appointment Scheduling, Registration, etc.		2					
F-32	32.014	The system shall provide a financial assessment screening process that collects appropriate information regarding indigent clients who may be potentially Medi-Cal eligible. Potential eligibility criteria may be configured by the system administrator in support of current California eligibility criteria.		2					
F-32	32.015	The system shall efficiently integrate Medi-Cal eligibility assessments processes with eligibility referral systems.	See Category 24 for eligibility referral support.	2					
F-32	32.016	The system shall support the collection of data required for the support of various pharmaceutical company indigent patient, "Patient Assistance Programs."	Moved from Order Medication: 11.042.	2					
F-32	32.017	The system shall be able to generate drug-specific "Patient Assistance Programs" applications forms to request medications at no cost from manufacturers.	Moved from Order Medication: 11.043.	2					
F-32	32.018	The system shall support the configuration of multiple "Patient Assistance Programs" application forms that shall be associated with specific medications.	Moved from Order Medication: 11.044.	2					
F-32	32.019	The system shall track the submission of "Patient Assistance Programs" forms and the status tracking of pending applications.	Moved from Order Medication: 11.045.	2					
F-32	32.020	Eligibilty Checking: The system shall be able to perform eligibility checking for batches of clients based on who is scheduled in the next 48 hours.		2					
F-32	32.021	Eligibilty Checking: The system shall notify patients of loss of eligibility.		2					
F-33	33.001	The system shall be able to identify by name all providers associated with a specific client service/treatment.	A provider is defined as anyone delivering clinical care such as physicians, PAs, CNPs and nurses; the provider is the person who completes the note.	2		H			
F-33	33.002	The system shall be able to specify the role of each provider associated with a client, such as service/treatment provider, primary care provider, attending, resident, or consultant.	This is simply meant as a means to define the provider role. Display of that data is not addressed.	2		L	M	H	
F-33	33.003	The system shall be able to specify the primary or principal provider responsible for the care of a client within a care setting.		2		H			
F-33	33.004	The system shall be able to create a list of all clients who have had an service/treatment with a given provider.		2		M	M	H	
F-40	40.001	The system shall be able to record mandated reporting data during the course of clinical care.	All mandated reports .	2		H			

F-40	40.002	The system shall be able to import XML Schema definition (XSD) files as provided by DMH.	MHSA Reporting	2		H			
F-40	40.003	The system shall incorporate the XSD as provided by DMH into the EHR. - talk to Lori/Marini	MHSA Reporting	2		H			
F-40	40.004	The system shall provide functionality to produce reports based on absence of mandated data elements.	All mandated reports	2					
F-40	40.005	The system shall provide a mechanism to add data based on reports that identify the absence mandated data elements.	All mandated reports	2					
F-40	40.006	The system shall generate error or suspension reports prior to sending a mandated report to DMH.	All mandated reports	2		H			
F-40	40.007	The system shall allow the user to specify the output format for mandated reporting. (e.g.. XML, CSV,etc).	All mandated reports	2					
F-40	40.008	The system shall produce reports in accordance with the record layouts required by DMH.	CSI Reporting	2					
F-40	40.009	The system shall cross walk local codes to values required by mandated reporting.	All mandated reports for example ethnicity code,	2					
F-40	40.010	The system shall efficiently meet California CSI and OSHPD Inpatient reporting requirements	County requirements for tracking key inpatient data include date of admission, referring provider, inpatient case manager, treating psychiatrist, outpatient authorization type, outpatient case manager, and date of discharge, admit and discharge diagnosis, legal status, etc.	2					
F-40	40.011	The system shall validate mandated reporting elements based on the date of service/treatment.	Example is: CSI Reporting - DMH requirements for service/treatment records shall be met.	2					
F-40	40.012	The system shall provide entry, creation and compliance tracking of the California Treatment Authorization Requests or similar locally defined authorization or notification forms, which are generated for inpatient admissions and submitted to the State's inpatient fiscal intermediary or similar party.		2					
F-40	40.013	The system shall track episodic data during the inpatient stay such as utilization review notes and user-defined checklists and can produce daily census and bed statistics reports for clients being managed by the county.		2					
F-41	41.001	The system shall appropriately adjudicate, reject, receive, and integrate ASC X12N 837 - Health Claims or Equivalent Encounter Information from external providers.		2					
F-41	41.002	The system shall allow manual entry of external Health Claims or Equivalent Encounter Information.		2					

F-41	41.003	The system EHR related claim adjudication shall be automated and adjudicate on a per claim basis.		2					
F-41	41.004	The system EHR related claims shall be adjudicated on user-defined rules including payor eligibility, whether other insurance plans are primary, the existence of an appropriate authorization, coverage for the specific service/treatment, service/treatment by an authorized provider, and covered diagnosis.		2					
F-41	41.005	The system shall efficiently integrate with systems that provide ASC X12N 835 - Healthcare Payment and Remittance Advice format reports.		2					
F-41	41.006	The system shall be able to forward External Provider ASC X12N 837 Health Claims to all claim payors.	This includes Short Doyle Medi-Cal, Medicare, Insurance, and other providers (such as other counties).	2					
F-41	41.007	The system shall efficiently allow for pending claims review and subsequent approval or denial of further claim submission.		2					
F-41	41.008	The system shall efficiently integrate with an accounts payable system that supports EHR related claiming.		2					
F-41	41.009	The system shall have ability to produce paper and electronic EOB and offer flexibility for user-defined letters to accompany EOBs.		2					
F-41	41.010	The system shall support the entry of claim adjustments where claims that have been entered, adjudicated, approved and paid can be reversed and credit balances cleared. These adjustments shall also be included in the Remittance Advices for specific providers/facilities.		2					
F-41	41.011	The system shall require all EHR claim payments and adjustment entries, including reversals, be supported by an audit trail, user-friendly screen views and reports.		2					
F-41	41.012	The system shall support the entry of payment and denial information from providers related to coordination of benefits where the county is not the primary payor; in many cases this is required prior to county payment of their secondary or tertiary responsibility.		2					
F-41	41.013	The system shall maintain claims payment history for all claims processed through the EHR claims processing module. These payments shall be supported by an audit trail, user-friendly screen views, and reports.		2					
F-41	41.014	The system shall coordinate all providers EHR related claims against claim payment limits.		2					

F-41	**41.015**	The system shall track all providers EHR related claim limits by vendor and payor source with user-friendly summary and detail information screen views and reports.		**2**					
F-41	**41.016**	The system shall generate related IRS Form 1099 documents each calendar year end.		**2**					
F-41	**41.017**	The system shall supports multiple contractor agreements detailing services funded by multiple payors with differing benefit designs and multiple provider reimbursement systems such as case rate, fee for service, capitation, and fixed fee payments.	Different benefit designs can include or exclude certain service/treatments based on diagnosis, coverage, or other attributes. A single provider can have multiple fee schedules based on health plan coverage or population served, including enhanced rates for service/treatments based on county-specific criteria such as language. Fee schedules have start and end dates, with history saved to support proper payment of late claims submitted after the end date of a given fee schedule.	**2**					
F-41	**41.018**	The system shall support payor reimbursement due to A/R adjustments.	Reimbursements may be due to overcharges, overpayments, incorrect service/treatment entry, incorrect software application routines, therapeutic adjustments, etc.	**2**					
F-42	**42.001**	The system shall integrate service/treatments provided with California Mental Health claiming requirements.	Reporting requirements include translations for mode of service code, minutes of service, number in group, clinician ID, and co-therapist ID. They also include following appropriate claiming rate protocols. Provider code will be either a numeric or an alphanumeric code which may translate to an individual private practice clinician, or an agency composed of several clinicians. The agency may be county operated or a contract facility. All such organizations or entities will have a provider code.	**2**					

F-42	**42.002**	The system shall have the ability to translate the California claiming requirements into the ASC X12N 837 - Health Claims or Equivalent Encounter Information format for billing.	Reporting requirements include translations for mode of service code, minutes of service, number in group, clinician ID, and co-therapist ID.	**2**					
F-42	**42.003**	The system shall receive, and integrate ASC X12N 835 - Payment and Remittance Advice data for internal providers claims adjudication.		**2**					
F-42	**42.004**	The system shall receive, integrate, and forward ASC X12N 835 - Payment and Remittance Advice data to external providers.		**2**					
F-42	**42.005**	The system shall correct and re-submit ASC X12N 837 - Health Claims, as appropriate.	This requirement includes correction and resubmission of claims denied by the state.	**2**					
F-42	**42.006**	The system shall void and/or replace previously submitted ASC X12N 837 - Health Claims, as appropriate.		**2**					
F-42	**42.007**	The system shall allow manual entry of internal and external receivables EHR service/treatment related Information.	This might be accomplished through linkage to manual service/treatment data entry. (See FR …)	**2**					
F-42	**42.008**	The system shall produce paper-based claims (such as HCFA-1500, UB-92 and user-defined formats) for any EHR service/treatment transaction on-demand or in a batch mode. This includes claims which are forwarded electronically to the county from contract providers for submission to payors and the corresponding forwarding of remittance advices back to the contract providers.		**2**					

F-42	**42.009**	The system shall support required billing rules for specific service/treatments and programs. Detail on these rules may be found in a variety of sources such as: CA DMH Information Notices; CA DMH Letters; CA DMH HIPAA 837 Companion Guide; CA DMH CSI manuals; future release of CA DMH SD-MC Provider Resource Manual; Federal OMB Circulars; and Federal Medicare Guidelines.	Examples of California billing requirements protocol which need appropriate handling: 1) Group Therapy billing - both groups with mental health clients only and groups with both mental health and non mental health clients; 2) Multiple staff billing on one client, such as during a case conference, or crisis event; 3) Medi-Cal service/treatments "lock-outs" ; 4) Billing all payor sources at the same rate; 5) Net Billing Medi-Cal after billing other payors such as Medicare; 6) Healthy Families population claiming; 7) AB3632/26.5 population claiming; 8) Restricting CalWorks client billing to SD-MC; 8) Medi-Cal Share of Cost applicability to SD-MC and client payors; 9) Client UMDAP based claims.	**2**					
F-42	**42.010**	The system shall be user-configurable to allow certain authorization types in the Authorization Management component to control whether an entered service/treatment is billed to a third party payor.	An example is if a provided service/treatment does not fall within the parameters of an existing authorization for a client (e.g. date range, provider, service/treatment code) the claim will be pended and listed on an error report or tickler system for follow-up.	**2**					
F-42	**42.011**	The system shall ensure that AB3632 service/treatments billed to government educational agencies are configurable to the service/treatments authorized in a youth's Individualized Education Plan (IEP) authorization.	Authorization requirements are bound by client enrollment, service/treatment type, service/treatments authorized, and authorization period.	**2**					
F-42	**42.012**	The system shall support multiple payors for a client service/treatment.	Support includes tracking and management of benefit limits, deductibles, copays, and covered and non-covered service/treatments for specific plans.	**2**					
F-42	**42.013**	The system shall support multiple fee schedules by payor including state-specific fee schedules such as the Medi-Cal AB3632 fee for service billing for children identified with a severe emotional disorder via a separate payor source with specific billing/adjust rules for that program.		**2**					

F-42	42.014	The system shall support easy updating of all client data related to payor coverage.	This includes specific plan benefit plan changes which may occur.	2					
F-42	42.015	The system shall support the management of multiple reimbursement methods including fee for service, case rates, per diem, capitation and grant-in-aid, and the bundling and unbundling of service/treatment codes by payor.	For example, certain service/treatments have to be bundle-billed to Medi-Cal, but those same service/treatments shall be individually billed to Medicare and private insurance.	2					
F-42	42.016	The system shall utilize retroactive enrollment data to produce payor claims for service/treatments originally billed to other sources and makes the proper adjustments to the relevant revenue, receivable and adjustment accounts. The system can retroactively bill these plans based on plan-specific retroactivity date limits.	This includes retroactive Medi-Cal, Medicare, and private insurance eligibility updates. Examples of plan-specific retroactive date limits is Medi-Cal service/treatments can be retroactively billed 12 months from the date of service/treatment and Healthy Families 24 months.	2					
F-42	42.017	The system shall support the setup of grant funding sources as quasi-insurance companies where clients who have no other coverage and meet funding sources eligibility requirements can have their service/treatments cascade to either a specific grant source (quasi-insurance company) or to a funding source group that may be billable to multiple grant sources. The system shall be configurable so that these charges can either be posted as outstanding accounts receivables that will be cleared by grantor payments, or automatically written off to a specific adjustment account. The system shall be able to track and report on the grant eligibility of all visits provided to individuals who are eligible for these funds.	Examples are CalWorks, SAMHSA, PATH, AB2034, MSHA FSP, AB3632/26.5 and MIOCR funding sources.	2					
F-42	42.018	The system shall support proper calculation of all client benefit-plan(s) co-pays and deductibles.	This includes integration with the Ca. DMH UMDAP fee schedule client liability calculations.	2					
F-42	42.019	The system shall support adjustments to outstanding client benefit-plan(s) balances.	This includes integration with the Ca. DMH UMDAP client liability adjustments.	2					
F-42	42.020	The system shall provide appropriate and accurate client billing for all outstanding copayments and deductibles.	This includes appropriate adjustment to UMDAP information originating from another provider. This includes client Medi-Cal Share of Cost Liability.	2					
F-42	42.021	The system shall provide HIPAA compliant electronic transmission of all client account receivable information from one provider to another.	This is especially important for A/R data transfer between Ca. counties since a Ca. client UMDAP liability is statewide specific, not provider specific.	2					

F-42	42.022	The system shall prevent Medi-Cal billing for clients with no known Medi-Cal eligibility during the month of service/treatment.	This requirement requires close integration with client Medi-Cal Share of Cost liability processes.	2					
F-42	42.023	The system shall provide user-friendly screen views related to all client co-pays and deductibles transactions.		2					
F-42	42.024	The system shall provide user-friendly reports related to all client co-pays and deductibles transactions.		2					
F-42	42.025	The system shall provide a user-friendly viewable audit trail for all client co-pays and deductibles transactions.		2					
F-42	42.026	The system shall provide a user-friendly reportable audit trail for all client co-pays and deductibles transactions.		2					
F-42	42.027	The system provide support client liability collection processes.	This includes support for documentation of attempts at obtaining client outstanding liability and support for adherence to provider A/R debt transfer protocols ("collections referrals").	2					
F-42	42.028	The system shall provide efficient electronic procedures to support bad debt write-off.		2					
F-42	42.029	The system shall support production of user-defined client billing statements on demand and on a cycle basis (e.g. every month) and has the capability of disabling the production of statements for any client.		2					
F-42	42.030	The system shall support classification of clients into categories for which the user will have control over the decision to print statements.	Examples are: 1) When the cost of billing exceeds the potential revenue to be billed client shall not be sent statements; 2) Clients who have Medi-Cal coverage shall not receive statements.	2					
F-42	42.031	The system shall support the identification and addressing to the correct receivor of the client billing statement.	Examples are: 1) Redirection of client statement to the client/guarantor, the client's conservator, or both.	2					
F-42	42.032	The system shall efficiently support client billing statements with user-defined provider messages.	These messages may be billing warnings, payment thank-you messages, or even care provider messages. The message writing protocols shall be based on provider billing message protocols.	2					
F-42	42.033	The system shall provide user-friendly statements printed in detail or summary format based on user-defined rules.		2					
F-42	42.034	The system shall have a client billing statement audit trail.		2					

F-42	42.035	The system shall provide a user-friendly viewable audit trail for all client billing statements issued.		2					
F-42	42.036	The system shall provide a user-friendly reportable audit trail for all client billing statements issued.		2					
F-42	42.037	The system shall support entry of standard service/treatment fees set by local, state or federal governance and post A/R transactions respectively.	Data supporting the standard service/treatment fees shall be locally defined but may include effective begin and termination dates, fee amount change date, change authorizer, ID of staff who made changes, and BOS date.	2					
F-42	42.038	The system shall support estimated costing of all provider service/treatments rendered (direct and indirect service/treatments).	The estimated cost of a direct service/treatment for a client is typically determined as stated in Standard fee setting requirement above. Estimated cost of either direct or indirect service/treatment is intended to assist the provider in managing or reporting on estimated year end service/treatment or program costs. Usage of this capability will be provider specific.	2					
F-42	42.039	The system shall support correlation of service/treatment fees to the related Statewide Maximum Allowance (SMA) set by the CA DMH.	The SMA is a SD-MC rate cap which is updated annually by CA DMH.	2					
F-42	42.040	The system shall integrate with A/R and G/L posting of contractual allowances and sliding scale adjustments for each service/treatment from all sources at the time of entry based on the billing rules entered for insurance companies and self-pay clients.		2					
F-42	42.041	The system shall support recording contractual allowances or sliding scale discounts adjustments to the standard fees.	Support may be demonstrable for postings to the county's general ledger via hard copy or electronic posting reports, which can be summarized based on user-defined criteria including subtotals by payor, payor class, program, location, etc.	2					
F-42	42.042	The system shall support the entry and proper tracking of multiple user-defined adjustment codes.	Examples of adjustment codes include contractual allowances, sliding scale discounts, incorrect fee postings, therapeutic adjustment authorized by county mental health director, and bad debt write-offs.	2					

F-42	**42.043**	The system shall support manual payment posting to client accounts receivable balances.	Client A/R balances encompass client liability calculations per rendered service/treatment fee and UMDAP rules.	**2**					
F-42	**42.044**	The system shall support issuance of sequentially numbered payment receipts.		**2**					
F-42	**42.045**	The system shall allow the posting of payments to a client account even though there are no related charges.	Payments may be shown as credit balances to be matched with charges at a later date per local county policy.	**2**					
F-42	**42.046**	The system shall support A/R linkage to A/P payments for required payor reimbursement.	Reimbursements may be due to overcharges, overpayments, incorrect service/treatment entry, incorrect software application routines, therapeutic adjustments, etc.	**2**					
F-42	**42.047**	The system shall support electronic posting of the ASC X12N 835 - Healthcare Payment and Remittance Advice to client accounts.		**2**					
F-42	**42.048**	The system shall support controls for reconciling payments entered due to cash receipts.		**2**					
F-42	**42.049**	The system shall support open item accounting that allows posting of payments and adjustments to specific charges/invoices.	http://www.delphipbs.com/help/html/openitemaccounting.htm	**2**					
F-42	**42.050**	The system shall support correct sequential billing of payors ensuring that the sequence is based on both the coverage that the client has and the service/treatments that are covered by the various plans. When Remittance Advices are posted, outstanding charges shall be automatically calculated and upon user confirmation, transferred to secondary and tertiary payors and/or client responsibility. Thereafter, appropriate electronic and paper claim forms shall be produced which include payments received from previous payors.	Examples of sequential payor billings are: 1) Medicare 1st, Private Insurance 2nd; Patient 3rd; 2) Patient 1st and Medi-Cal 2nd	**2**					
F-42	**42.051**	The system shall support that outstanding charges not confirmed and transferred to the next sequential payor remain as an open receivable.		**2**					
F-42	**42.052**	The system shall support that appropriate audit trails are kept of claims that have been sequentially billed to multiple payors.		**2**					
F-42	**42.053**	The system shall support automatic crediting of contractual allowance and other adjustment accounts during payment posting based on predetermined carrier-specific criteria.		**2**					

F-42	42.054	The system shall ensure that revenue and A/R balances do not overstate outstanding amounts by reporting balances for multiple payors simultaneously.		2					
F-42	42.055	The system shall track and report A/R data related to client service/treatments via detailed aged accounts receivable reports with user-defined sort and subtotal criteria including payor, provider, client, program, location, etc.		2					
F-42	42.056	The system shall compute and automatically write off of positive or negative contractual allowance amounts for bills that are covered by capitated or grant-in-aid funding streams.		2					
F-42	42.057	The system shall support screen views for all client accounts that show the transaction history of all charges, payments, and adjustments for all payors for a specified date range.	These screen views shall allow filtering to show the same information for a single payor (including client responsibility).	2					
F-42	42.058	The system shall be able to attach and display user notes to any transaction.	Examples of notes are: 1) Notes regarding collection calls to clients; 2) Client verbal consents re: account payments; 3) Follow up notes to provider staff.	2					
F-42	42.059	The system shall support production of tickler system reports based on the follow-up dates entered into A/R transaction notes.		2					
F-42	42.060	The system shall efficiently support timely completion of the required end of year cost DMH SD/MC Cost Report.	Includes accurate compilation of related units of service, time, charges, payments and classifications accordingly. Classification might be by provider; age; program target population; payor source such as Healthy Families, AB3632/26.5, EPSDT, Medi-Cal, Medicare, Medi-Cal/Medicare Crossovers, Insurance, and indigent; California's mode and service function code structure.	2					
F-42	42.061	The system shall efficiently support timely completion of a monthly, quarterly, and semi-annual projected end of year cost DMH SD/MC Cost Report.		2					
F-42	42.062	The system shall efficiently support timely completion of required monthly, quarterly, and semi-annual grant funding reports.	Examples are PATH, SAMHSA, MIOCR, AB2034, and MHSA grant funding.	2					
F-42	42.063	The system shall have a single-entry system for both on-site and off-site service/treatments.		2					

F-42	42.064	The system shall have the ability for electronic download and upload of data, including third party (e.g., Medicare, Medi-Cal, insurances) and state programs.		2					
F-42	42.065	The system shall support both real-time and batch entry of client service/treatment charges.		2					
F-42	42.066	The system shall be able to record fees collected at the beginning of each visit.		2					
F-42	42.067	The system shall allow for the ability to re-bill errors individually and in batch.		2					
F-42	42.068	The system shall allow re-billing of any unpaid accounts by payor type at the user's choice (e.g., insurance carrier not paid within 60 days and no EOB received).		2					
F-42	42.069	The system shall allow for both primary and secondary insurances to be billed electronically.		2					
F-42	42.070	The system shall maintain fees for all items which the user identifies as billable. This fee schedule has restricted access and can be updated by the system administrator when necessary.		2					
F-42	42.071	The system shall be able to bill FQHC rates or per-diem amount established by the funding third party carrier currently Medicare and Medicaid).	FQHC – Federally Qualified Health Center	2					
F-42	42.072	The system shall allow the ability to establish multiple sliding fee scales, set alternate client fees with a date range when the fee is in effect.		2					
F-42	42.073	The system shall automatically determine the sliding fee category based on family size and income. A review date is established for review of the sliding fee.		2					
F-42	42.074	The system shall be able to pull up all billing related to a specific service/treatment site or for service/treatments billed throughout the agency, and to attribute payments to specific service/treatments.	Display includes claims, payments, denials, re-billings	2					
F-42	42.075	The system shall be able to identify the client's co-payment (sliding fee) as a component of the total amount due (able to identify what is outstanding for insurance billing, for example, and what the client must pay out of pocket.)		2					
F-42	42.076	The system shall be able to determine which payor to submit the bill to based on service/treatments provided (based on procedure code, service/treatment location, payor requirements) or by the priority of the payor as defined in the system.		2					
F-42	42.077	The system shall default the visit diagnosis to the last or the chronic diagnosis based on the preference set by the user.		2					

F-42	42.078	The system shall display the primary, secondary and tertiary insurance for selection during charge entry (defaults to primary) and allows changing insurance assignments as necessary.		2					
F-42	42.079	The system shall prompt the user with the procedure code and fees associated with the selected insurance carrier.		2					
F-42	42.080	The system shall support splitting of global fees into user-defined components.		2					
F-42	42.081	The system shall prevent users from entering procedures to incorrect sites, departments or providers.		2					
F-42	42.082	The system shall have an automated link to benefits determination for Medicare, Medicaid and third-party insurance.		2					
F-42	42.083	The system shall be able to print encounter forms and receipts, giving the client a printed summary of payments and outstanding charges at each service/treatment, listing the procedure charge and the amount of the discount given.		2					
F-42	42.084	The system shall be able to write off balances not covered by selected payors when payment is received (e.g., Medicaid accepted as payment in full.)		2					
F-42	42.085	The system shall allow that specified bills can be generated at any time, e.g., can print individual client bill without waiting to batch bills weekly or monthly.		2					
F-42	42.086	The client billing statement shall include: Client name, client address, client identifier number, provider, program name, dates of service/treatment, procedure codes, prior balance, fees charged since last billing statement, applicable account adjustments, and balance due.		2					
F-42	42.087	The system shall support automatic translation of entered diagnoses and procedure codes to alternate state and third-party payor-mandated coding methodology for reimbursement claim forms.		2					
F-42	42.088	The system shall be able to record the payment schedule by procedure code, by insurance plan, allowing the user to add, edit, and delete tables for most common payors.		2					
F-42	42.089	The system shall allow the user to define the pertinent questions to be asked per payor at intake and throughout service/treatment.	Different payers have different information requirements.	2					
F-42	42.090	The system shall allow the user to suspend billing a client pending a response from a third-party payor. A notation field indicates the reason for the suspension of client billing.		2					

F-42	42.091	The system shall reflect client bills all appropriate account adjustments.		2					
F-42	42.092	The system shall allow the system manager to modify the format of the client or family statements with out vendor intervention.		2					
F-42	42.093	The system shall be able to establish and have bills adjust to a center-specific sliding fee scale policy including; minimum fee by procedure code, minimum fee per visit, minimum fee by department (or some combination of these), sliding fee as a percentage of full charge, ability to identify procedures ineligible for sliding fee.		2					
F-42	42.094	The system shall be able to suppress billing statement in select user-defined situations.		2					
F-42	42.095	The system shall display comments or flags indicating special conditions associated with individual clients or their accounts.		2					
F-42	42.096	The system shall access insurance companies' eligibility files.		2					
F-42	42.097	The system shall interface with the scheduling system so that clerical staff shall receive automated billing messages when clients come for scheduled appointments.		2					
F-42	42.098	The system shall combine and submit on one bill all service/treatments provided to one client on the same day.		2					
F-42	42.099	The system shall use single source billing.		2					
F-42	42.100	The system shall make accessible and able to sort on a date basis a client's entire payment history.		2					
F-42	42.101	The system shall be able to track payments and credit the appropriate program site where the charges occurred.		2					
F-42	42.102	The system shall support development of budget plans and bills first/second party payors according to the budget plan agreement.		2					
F-42	42.103	The system shall be able to post receipts as a batch, with repetitive entries keyed only once.		2					
F-42	42.104	The system shall be able to keep a running total to tie receipts to an intermediary's check and to the total of the bank deposit.		2					
F-42	42.105	The system shall track the status of each outstanding payor balance by the age of the balance (intervals of 30 days up to 150 days) and by whether or not a minimum payment (% of the amount due), a full payment, or no payment have been made against the outstanding balance.		2					

F-42	42.106	The system shall be able to generate aging reports at these 30 day intervals by user-defined categories such as department, payor site.		2					
F-42	42.107	The system shall be incompliance with GAAP.	GAAP – Generally Accepted Accounting Practices	2					
F-42	42.108	The system shall be able to post a receipt to a specific month of service/treatment, oldest balance or to individual open items. It shall provide the flexibility in how receipts are posted. For example; the ability to post the current month's receipts even if the prior month is not closed.		2					
F-42	42.109	The system shall be able to post adjustments to a prior month.		2					
F-42	42.110	The system shall allow global rate adjustments and all affected accounts shall be adjusted automatically.	Example: When fee schedules change.	2					
F-42	42.111	The system shall generate a complete audit trial of all adjustments to billings.		2					
F-42	42.112	The system shall be able to bill multiple payors in the way required (service units, CT codes, etc.).		2					
F-42	42.113	The system shall provide edits in order to prevent entering non-valid data.		2					
F-42	42.114	The system shall be able to use effective dates for certain data (such as procedure codes).		2					
F-42	42.115	The system shall be able to drive billing off of the client records (link to progress note entries).		2					
F-42	42.116	The system shall provide a "tickler system" for tracking the activities associated with managing collection accounts.		2					
F-42	42.117	The system shall produce a report of all credit balances.		2					
F-42	42.118	The system shall be able to update balances due and perform aging of client accounts in real-time when payment is received.		2					
F-42	42.119	The system shall track patient charges, credits and remittance history.		2					
F-42	42.120	The system shall be able to print a day log of all transactions processed by a staff member or site to facilitate cash drawer reconciliation and encounter form tracking.		2					
F-42	42.121	The system shall issue monthly mailing statements that confirm to specifications of the US Postal Service including printing ZIP+4 and bar coding requirements.		2					
F-42	42.122	The system shall display the account status information from accounts receivable via an account status indicator or code on the client registration screens.		2					

F-42	42.123	The system shall include: Real time aging reports, collection note fields for follow up information, collection payment reports by department, collection payment reports by site.		2					
F-42	42.124	The system shall be able to indicate an account is in collection process and the ability to run reports on accounts so designated.		2					
F-42	42.125	The system shall generate template collection letters from data in the collection database.		2					
F-42	42.126	The system shall include reminders that the next letter or action is due for a specific account.		2					
F-42	42.127	The system shall maintain a history of statements mailed to clients, including the date and type of the statement sent.		2					
F-42	42.128	The system shall generate reminder notices to the agency and to clients with expired sliding fee review dates.		2					
F-42	42.129	The system shall be able to bill all payors of a client electronically as well as manually.	Examples: Medicare, Medicaid, CA Department of Mental Health, CA Department of Alcohol and Drug, private pay, insurers and of third party payors.	2					
F-42	42.130	The system shall be able to print special billing forms.	Example: UB92.	2					
F-42	42.131	The system shall be capable of automatically calculating contractual adjustments based on user setup.		2					
F-42	42.132	The system shall be able to post and track capitation payments by insurance carriers.		2					
F-42	42.133	The system shall be able to run revenue projection reports using current census information.		2					
F-42	42.134	The system shall be able to run daily and monthly cash drawer reports (encounter reports).		2					
F-42	42.135	The system shall run revenue reports by various parameters to show amount billed, revenue received, amount outstanding, and amount denied.	Parameter examples: Provider, type of service/treatment, funding source, and program.	2					
F-42	42.136	The system shall be able to resubmit denied claims with appropriate corrections.		2					
F-42	42.137	The system shall be able to transmit valid void and replace HIPAA 837 transactions to all payor sources accepting such transactions.	Examples are: : Client account number, sources of funding available to client, UMDAP liability.	2					
F-42	42.138	The system shall interface with the Registration functions so that at the initial client contact the system can display critical information.	Examples are: : Client account number, sources of funding available to client, UMDAP liability.	2					
F-42	42.139	The system shall link service/treatment transactions and medical/nursing data in order to eliminate redundancy and to ensure that service/treatments billed match services provided.		2					

F-42	**42.140**	The system shall interface the A/R function with the Scheduling function so that the status of a client's account is available: At the time the appointment is made and when the client arrives for service/treatment.		**2**					
F-42	**42.141**	The system shall interface the A/R function with the Registration and Scheduling functions so that the status comments and an account status indicator associated with the client account is displayed.		**2**					
F-42	**42.142**	The system shall immediately reflected all changes to a client's registration information in the A/R data.		**2**					
F-42	**42.143**	The system shall provide an inquiry function that enables the user to view with following elements of an A/R account:	Examples are: service/treatment charges, guarantor information, account status codes, client account balances, third party payor account balances, assignment acceptance, and third party payor effective dates.	**2**					
F-42	**42.144**	The system shall allow detailed financial transactions to be reported or displayed in chronological order by posting date and include various data.	Examples of data are: Date of service/treatment, member of account receiving care, posting date, provider's name, site of service/treatment, transaction amount, claim identifier number, payer, and status of claim.	**2**					
F-42	**42.145**	The system shall sort and print to any printer a patient's account information sorted by pay code (charges, discounts, and payments).		**2**					
F-42	**42.146**	The system shall make available a summary report that shows the last payment date, last payment amount, and credit balance for a patient's account associated with any payor.		**2**					
F-42	**42.147**	The system shall post support double entry accounting.		**2**					
F-42	**42.148**	The system shall distinguish account credits and debits from debit adjustments and credit adjustments.		**2**					
F-42	**42.149**	The system shall allow data entry as on-line or batched. Batched transactions may be optionally edited on-line (additions, changes, deletions) prior to posting transactions to the accounts.		**2**					
F-42	**42.150**	The system shall associate all transactions with the client, the account, the name of the person who posted the transaction, the posting date, the name of the transaction, the dollar amount of the transaction, and the transaction type.		**2**					

F-42	42.151	The system shall associate each charge item with: Date of service/treatment, payer, provider, department/program, procedure code, funding source, site of service/treatment, type of service/treatment, override fee flag, user defined comment field, charges to which payment is applied, payor identifier numbering.	Examples of payor identifier numbering: Client check number and check bank number, State warrant number.	2					
F-42	42.152	The system shall associate each adjustment with: Date of service, provider, department, program, funding source cost center, type of adjustment, comment/notation area.		2					
F-42	42.153	The system shall post third party payments to particular visits designated by the payor as well as to the outstanding balance (as a unit).		2					
F-42	42.154	The system shall provide a journal entry for the general ledger detailing revenue, adjustments, payments, bad debts, refunds by account number (segmented by site and department). The GL entry and A/R reports shall be run at any time after the close of the period and shall not be changed.		2					
F-42	42.155	The system shall be able to automatically write-off accounts based on insurance plan, date of service/treatment, and threshold balance.		2					
F-42	42.156	The system shall be able to post denials with codes into the system electronically.		2					
F-42	42.157	The system shall provide a report to reconcile amounts written off to bad debt.		2					
F-42	42.158	The system shall provide a report to reconcile amounts refunded to clients.		2					
F-42	42.159	The system shall provide a daily transaction log that lists the detail of all the transactions entered each day.		2					
F-42	42.160	The system shall include a daily transaction log with the date and time each transaction is generated.		2					
F-42	42.161	The system shall include a daily transaction log organized by patient name in alphabetical order or by account number; the order is user-defined and may be changed from one accounting period to another.		2					
F-42	42.162	The system shall include a daily transaction log with following detail within each account: Date of service/treatment, posting date, provider's name, transaction description, transaction type, and transaction amount.		2					
F-42	42.163	The system shall generate a bank deposit sheet listing all checks (with bank and check numbers) their dollar amounts, and the total amount for deposit.		2					

F-42	42.164	The system shall generate a cash receipt log (cash and checks) broken out by facility or by program, and/or by provider.		2					
F-42	42.165	The system shall provide an Aged Trial Balance (ATB) report, in alphabetical order by guarantor/payor name that shows all outstanding receivables on all non-zero balance accounts. Aging is presented in 30 day intervals up to 150 days. This report can be run at the user's option in a user-selected date of service/treatment range (i.e., not mandatory to run each month.)		2					
F-42	42.166	The system shall provide an ATB that shows for all accounts with charges in suspense aging of the system amounts by insurer and site.		2					
F-42	42.167	The system shall show include with each account description: Payor's name, account number and telephone number.		2					
F-42	42.168	The system shall have an ATB report that includes totals for the entire practice by age category for guarantor responsibility and for each third-party payor with suspended amounts.		2					
F-42	42.169	The system shall have an ATB report that is sorted by insurance, number of days outstanding, sliding fee type, or credit code.		2					
F-42	42.170	The system shall provide a monthly Outstanding Third-Party Charges report that shows aged totals for all third-party payors. It includes claims currently in suspense by account		2					
F-42	42.171	The system shall have an Outstanding Third-Party Charges report that is sorted by site, by program, and/or by payor.		2					
F-42	42.172	The system shall produce both detail and summary receivable reports by client financial status, by age and amount due, by location, by provider, accounts with credit balances, and overdue accounts that are candidates for collection.		2					
F-42	42.173	The system shall provide an A/R Ledger that is subdivided into non-zero balance and zero-balance accounts; the non-zero balance accounts are shown with the date and/or number of days since the last payment/activity.		2					
F-42	42.174	The system shall provide Revenue Analysis report(s) that break(s) out revenue or gross charges by: Entire system, provider, site, program, payor, cost center, or any combination of these.		2					

F-42	**42.175**	The system shall provide a Detail Revenue Analysis report that must show Adjusted Gross Charges by applying contractual adjustments to Gross Charges. Charge Adjustments are subtracted from Adjusted Gross Charges to arrive at Net Billable Amounts. Adjustments to Gross Charges include Reversal of Charges.		**2**					
F-42	**42.176**	The system shall have a Revenue Analysis Report(s) which can be run on a cash basis showing charges, adjustments, and payments at the time the report is run.		**2**					
F-42	**42.177**	The system shall have a Revenue Analysis Report(s) which can be run on an accrual basis showing charges for prior periods, related adjustments, related payments, and net balances by associated period.		**2**					
F-42	**42.178**	The system shall produce a Capitated Client List that shows insurance information for all clients under capitation.		**2**					
F-42	**42.179**	The system shall produce an Encounters for Patients Without Third Party Coverage report that lists clients' full names, their social security numbers, and all encounters and their associated charges within a user-specified date range for clients that show no insurance coverage on their accounts. This report can be used to check Eligibility for medical reimbursement.		**2**					
F-42	**42.180**	The system shall provide the capability of identifying how much has been billed, where the claims were sent and the current status of the claims.		**2**					
F-42	**42.181**	The system shall provide reports including year-to-date comparisons by insurance company and/or physician or outstanding claims by physician.		**2**					
F-42	**42.182**	The system shall provide billed/allowed reports that detail billed and expected claim amounts.		**2**					
F-42	**42.183**	The system shall be able to produce reports of patients and customers with credit balances.		**2**					
F-42	**42.184**	The system shall be able to print/preview detailed accounts receivable reports based on types of insurance carriers.		**2**					
F-42	**42.185**	The system shall be able to review patient payment histories and Medicare confirmations and rejections.		**2**					
F-42	**42.186**	The system shall be able to Create Overdue Payment Notes per aging report time period in client statements.		**2**					
F-42	**42.187**	The system shall be able to track amounts charged, expected payment, amount paid, adjusted, or refunded, and any balance due.		**2**					
F-42	**42.188**	The system shall provide a report for work unpaid visits, overpaid visits, and/or NSF payments.		**2**					

F-42	42.189	The system shall be able to view visit and payment history by either client or guarantor.		2					
F-42	42.190	The system shall be able to view summary of all outstanding receivables and “drill down” to review line item details such as payments and adjustments.		2					
F-42	42.191	The system shall be able to use flexible parameters available for moving unpaid visits into collections.		2					
F-42	42.192	The system shall be able to track contract dates.		2					
F-42	42.193	The system shall be able to input collections notes; generate collections notes.		2					
F-42	42.194	The system shall be able to group insurance carriers for collections purposes.		2					
F-42	42.195	The system shall be able to automate collections letters.		2					
F-42	42.196	The system shall be able to prevent billing/claiming until related notes are finalized.	Copied from Manage Clinical Documents: 8.026	2					
F-42	42.197	The system shall provide client service/treatment payor billing based on clinical service/treatment note entry.	Copied from Manage Clinical Documents: 8.060. This approach is in contrast to billing caused by client service/treatment data entry procedures which are performed separate from clinical service/treatment note entry.	2					
F-42	42.198	The system shall prevent inappropriate duplicative claiming of service/treatment rendered.	Moved from Service/Treatment Management: 30.017.	2					
F-42	42.199	The system shall prevent any Medi-Cal claiming for service/treatments rendered while client is located in an Institution for the Mentally Diseased (IMD).	Moved from Service/Treatment Management: 30.018.	2					
F-42	42.200	The system shall prevent billing Medi-Cal for board & care costs of an Psychiatric Health Facility (PHF).	Moved from Service/Treatment Management: 30.019.	2					
F-42	42.201	The system shall have user-friendly routines for updating service/treatment charge rates.	Moved from Service/Treatment Management: 30.020.	2					
F-42	42.202	The system shall allow payor source to be determined by both service/treatment type.	Moved from Service/Treatment Management: 30.024.	2					
F-42	42.203	The system shall allow payor source to be determined by service/treatment program.	Moved from Service/Treatment Management: 30.025.	2					
F-42	42.204	The system shall be able to associate a service/treatment with a funding source governed by effective start / end boundaries.	Moved from Service/Treatment Management: 30.026. Examples are: 1) AB3632 IEP service/treatments; 2) Grant funding timeline restrictions; 3) Insurance company or another county authorization period boundary dates;	2					

F-42	42.205	Payment Posting: The system shall provide the ability to post a client's co-pay at time of check-in		2					
F-42	42.206	Payment Posting: The system shall provide automated EOB posting for multiple patients from individual payers		2					
F-42	42.207	Payment Posting: The system shall provide the ability to post insurance payments for multiple patients via batch posting where the software counts down the dollar amount of the check as payments and adjustments are posted to each patient's account.		2					
F-42	42.208	Payment Posting: The system shall provide automatice insurance adjustments for electronic EOB transactions.		2					
F-42	42.209	Payment Posting: The system shall be able to identify when the insurance plan is not paying the appropriate pre-approved amount.		2					
F-42	42.210	Payment Posting: The system shall provide a report showing under payments based on the plan's specific providers' contract.		2					
F-42	42.211	Payment Posting: The system shall provide the ability to post patient payments via a secure internet connection.		2					
F-42	42.212	Payment Posting: The system shall provide the ability to post patient payments via a secure internet connection.		2					
F-43	43.001	The system shall support provider ability to account for all daily staff time including indirect service/treatments which are service/treatments not attributable to a specific client.	The nature of such service/treatments is configurable by the system administrator. They may include education, prevention and various community service/treatments for persons who have not been registered as clients. A variety of over-head activities including administration, supervision, training, QI, record keeping and other activities may be tracked by staff person.	2					
F-43	43.002	The system shall have system administrator capacity to create a variety of critical incident types that can be easily entered and retrieved.	Follow-up responsibility and other configurable fields allow local policy for incident reporting to be supported by this system feature.	2					
F-43	43.004	The system shall provide users an on-line personal task list.	The online personal task list shall include items linked to varied sources like: client appointments for the day; staff meetings; QI reminders on record problems; triggered alerts based on local policy and procedures (e.g. time to renew a service/treatment plan). The personal task list may be interfaced with products such as Outlook and Lotus Notes.	2					

F-43	**43.005**	The system shall include the ability to load, search and retrieve documentation related to local policies and procedures.	These policies and procedures can be linked to the related data screen entry screens. All policy and procedure information can be edited and managed using Microsoft standard text processing capabilities.	**2**					
F-43	**43.006**	The system shall support the development of user-defined screens for gathering data related to the quality management process. This includes user-defined customer satisfaction surveys, customer complaint and compliment forms, provider satisfaction surveys, etc.	Examples are CA DMH POQI's and CA MHSA DCR	**2**					
F-43	**43.007**	The system shall efficiently support integration with systems that can be used to generate generally accepted accounting standards (GAAP)-compliant, double-entry uploads of billing and claims transactions into the county's general ledger and accounts payable systems.		**2**					
F-43	**43.008**	The system shall support data entry alternative interfaces for items such as encounter forms, customer satisfaction surveys, and performance outcome instruments. Methods include scanning, optical character recognition, and intelligent character recognition.		**2**					
F-43	**43.009**	The system shall support the automation of business procedures or "workflows" for which documents, information or tasks are passed from one participant to another in a way that is governed by pre-defined rules or procedures. The system provides the user with guidance as to the various screens required to perform standard procedures.	For example, an admission may require several steps including multiple screens. Omission of key steps will prompt guidance from the system.	**2**					
F-43	**43.010**	The system shall support workflow advisories customized to reflect processes appropriate for particular target groups and organizations.	Examples are: 1) Client registration process queues up client to complete process for required Medi-Cal Share of Cost payments necessary prior to service/treatment being provided; 2) Client registration process broadcasts instant urgent message for clinical support needed in clerical support environment; 3) Billing staff informed that a client has not followed up with payment action as agreed upon; 4) A clinician is notified professional license expires in 60 days.	**2**					

F-43	**43.011**	The system shall support workflow advisory interfaces with standard e-mail systems.	Examples are: 1) E-mail automatically sent to client case coordinator that care plan is due; 2) E-mail automatically sent to appropriate oversight supervisor of an action that has not been completed.	**2**					
F-43	**43.012**	The system shall support workflow advisories that are generated once or repeatedly depending on local business rules.		**2**					
F-43	**43.014**	The system shall support efficient workflows in a Call Logging system.		**2**					
F-43	**43.015**	The system shall support efficient workflows in a Pre-Registration system.	Supports user-defined online pre-registration forms to gather initial client demographic and financial resources information for individuals requesting service/treatment. If the client becomes registered for service/treatment this information can be forwarded to Registration so that duplicate data entry is not required. If the client is already registered as a client in the system this shall be flagged	**2**					
F-43	**43.016**	The system shall support efficient workflows in an Intake Screening system.	Supports user-defined online client screening forms to assist in the determination of whether the client requires service/treatments from the crisis system, hospitalization, referral for outpatient service/treatments, or referral to other community resources. Includes access needs information, presenting problems and other relevant clinical information.	**2**					

F-43	**43.017**	The system shall support efficient workflows in a Referral Management system.	Supports detailed provider profile information for clinicians working at county clinics, independent providers in the provider network, and at contracted provider organizations. Clients can be matched to clinicians based on multiple variables in the Provider Registration Database. This includes information about provider location, specialties, non-English language capability, etc.	**2**					
F-43	**43.018**	The system shall support the issuance and tracking of service/treatment referrals by counties to members of their internal and external provider networks, which are compliant with the ASC X12N 278 - Referral Certification and Authorization format.		**2**					
F-43	**43.019**	The system shall allow users to customize the referral management screens, including the sort and selection criteria, as well as referral letters that can be sent to clients and providers.		**2**					
F-43	**43.020**	The system shall be able to upload information electronically to the Provider Registration Database.	This component is closely linked to the Authorization Management system, that handles when a referral is made and the county is responsible for payment of the service/treatments associated with that referral.	**2**					
F-43	**43.021**	The system shall support efficient workflows in accessing community resource databases.	Allows for the uploading or manual entry of community resources into a searchable database that can be filtered based on user criteria. Counties shall have the option of storing these entries in the provider referral database in ways that keep these records separate from the listing of network providers, or in a separate table that has the same lookup and tracking capacities of the provider referral database.	**2**					

F-43	**43.022**	The system shall support efficient workflows in a Wait List Management system.	Supports the ability to enter prospective clients on a wait list if space is not available for them at a provider that can meet their clinical needs. All wait listed clients will be entered into a user-defined online form that gathers information such as date of entry, referral type, reason for wait list, priority, expected appointment date, etc. Information on the wait list screen can be updated as additional data is gathered or client circumstances change.	**2**					
F-43	**43.023**	The system shall support tracking and sorting prospective clients by priority to assist in moving individual into service/treatment in the proper order.		**2**					
F-43	**43.024**	The system shall generates Request for service/treatment logs, which are available to the state and show the status of clients on the wait list at a given point in time.		**2**					
F-43	**43.025**	The system shall support efficient workflows in a Grievance and Complaints system.		**2**					
F-43	**43.026**	The system shall support client admission and discharge from organizational providers through a user-defined online admission/discharge form, which can be customized for different types of provider organizations.		**2**					
F-43	**43.027**	The system shall support efficient transfer of client information during client transfer from one organizational provider to another.		**2**					
F-43	**43.028**	The system shall support efficient workflows between California Mental Health data systems and California Alcohol and Drug data systems.	This is intended to support seamless county operations of clients that have MH diagnoses, A&D diagnoses, or both.	**2**					
F-43	**43.029**	The system shall support flagging episodes for closing due to service/treatment inactivity.		**2**					
F-43	**43.030**	The system shall support workflows that allow for the efficient coordination of system functions required for processing of clients who are opened and closed on the same day.	Examples of system functions that require special attention for efficient workflow management are episodic and service/treatment functions.	**2**					
F-43	**43.031**	The system shall support the tracking of clients by unit, room and bed, and midnight bed checks for 24 hour client service/treatments; this system can be used to generate daily room charges. This component tracks facility capacity and documents bed availability.		**2**					

F-43	43.032	The system shall support the tracking of dietary requirements for each 24 hour patient by unit, room and bed and creates dietary orders for the kitchen based on the dietary orders.		2					
F-43	43.033	The system shall support the recording and tracking of client valuables that are held on each unit of an inpatient or residential facility.		2					
F-43	43.034	The system shall support scanning key documents and organizing them into a logical structure that allow providers to easily view these documents. These scanned documents shall be able to cross-reference to paper charts.	Intended to cover internal document scanning as well as external document scanning found in "Capture external clinical documents" requirement category above.	2					
F-43	43.035	The system shall support single sign-on software products, while maintaining internal security controls.		2					
F-43	43.037	The system shall be able to auto-populate user defined data fields with patient demographics.		2					
F-43	43.052	The system shall manage business rules for decision support, diagnostic support, workflow control, access privilege, and other local business rules.		2					
F-43	43.053	The system shall manage business rules with create, import, access, update, local customization, inactivation, obsolescence, and audit trail management capacity.		2					
F-43	43.054	The system shall provide business rules audit trails.		2					
F-43	43.055	The system shall use workflow-related business rules to direct the flow of work assignments.		2					
F-43	43.056	The system shall create and manage workflow (task list) queues.	May be thru system interfaces.	2					
F-43	43.057	The system shall create and manage human resources workflow queues.	May be thru system interfaces.	2					
F-43	43.058	The system shall be capable of electronically distributing information to and from internal and external parties.		2					
F-43	43.059	The system shall be able to route notifications and tasks based on system triggers.		2					
F-43	43.060	The system shall dynamically escalate workflow according to business rules.		2					
F-43	43.061	The system shall dynamically redirect workflow according to business rules.		2					
F-43	43.062	The system shall dynamically reassign workflow according to business rules.		2					

F-43	**43.063**	The system shall be able to retrieve and display client encounter data by various user-defined parameters	Examples include: Data entry date, encounter, date, client identifier, encounter type, client provider identifier, diagnosis, referred provider, client care funding, and client financial liability.	**2**					
F-43	**43.064**	The system shall allow users to customize the presentation and data included in all system generated client and staff alerts.		**2**					
F-43	**43.065**	The system shall be able to print all alerts on demand.		**2**					
F-43	**43.066**	The system shall be able to forward an alert to specific provider(s) or other authorized users via secure electronic mail or by other means of secure electronic communication.		**2**					
F-43	**43.087**	Automated Process Flow: The system shall prompt staff for the information that should be gathered during a specific process. For example, when checking in a Medicare Patient, have the patient complete and sign selected forms		**2**					
F-43	**43.088**	Automated Process Flow: The system shall create the required forms on a tablet so that the patient can sign all required forms without the need to print the paper.		**2**					
F-43	**43.089**	Automated Process Flow: The system shall create the required forms on a tablet so that the patient can sign all required forms without the need to print the paper.		**2**					